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From Documenting Death to Comprehensive Care: Applying Lessons from the HIV/AIDS Epidemic to Addiction

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In recent years, we have seen a rising tide of deaths documented in Centers for Disease Control and Prevention reports that bears a chilling familiarity to the early years of the human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) epidemic. These deaths are from opioid overdoses, due to the underlying disease of opioid addiction, just as AIDS deaths are due to the underlying HIV infection. Overdose from opioid addiction now kills more Americans than motor vehicle crashes or firearms.¹ As with HIV/AIDS, many of the victims are young, previously healthy, and already stigmatized, with effective care hindered by a public impression that only certain groups of people become opioid addicts. While the death toll of these parallel epidemics is comparable, the efficacy of the response to opioid addiction has yet to match that of HIV/AIDS. As tangible evidence of our failure to effectively disseminate addiction treatment, every 19 minutes another American dies from an unintentional overdose.¹

LOOKING BACK AT THE HIV/AIDS EPIDEMIC

Following initial descriptions of what would become HIV/AIDS in 1981, it took another 4 years, 15,527 AIDS cases, and 12,529 deaths for the government to publicly discuss and begin to direct resources toward the epidemic.² In the intercurrent years, physicians and the public watched as the death toll mounted and 71 Centers for Disease Control and Prevention-published reports documented the spread of illness and mortality. While initially declared to be a disease of young homosexual men, termed “the gay plague,” as hemophiliacs, women, and children were affected, it became clear the disease was related to behavior and not sexual orientation.³ A combination of public fear at the growing impact of

HIV/AIDS, the political power of gay men, and concern about stigmatization and discrimination led to a novel public health approach based on human rights.⁴ Biomedical breakthroughs proffered hope, life-saving treatment, and a new disease conceptualization. In addition, community advocacy and activism played a fundamental role in shaping the response, with the slogan “nothing for us without us” capturing the involvement of affected populations.² Now, 30 years later, the global response to HIV/AIDS has demonstrated an unprecedented commitment of resources and international aid,³ and there are predictions of a notso- distant end to the AIDS epidemic.

TODAY’S EPIDEMIC: OPIOID ADDICTION

Addiction affects 40 million Americans, or 15.9% of the population, more than heart conditions, diabetes, or cancer, and opioid use disorders are the fastest growing type of drug problem.^{1,5} Regrettably, much of the current generation’s exposure to opioids has been due to the explosion of widely available, potent prescription painkillers, which have an identical effect in the brain as heroin. The increased accessibility has been linked to a combination of heavy marketing by the pharmaceutical industry combined with regulatory pressure to improve patient satisfaction and cultural shifts in physician prescribing. Although many benefit from substantial pain relief and quality-of-life improvement, prescription opioids now kill more people than heroin and cocaine combined.¹

The disease of opioid addiction follows a predictable path of progression. Like many diseases, a person’s vulnerability for developing addiction depends on genetics, environmental factors, and exposure. With the increase in prescription opioid availability, a common narrative is early exposure to painkillers, either through medical treatment or experimentation with diverted pills. For many who continue to use, there is an inevitable transition from the euphoria of early use to tolerance and withdrawal. The individual goes from *using to feel good* into a state of *needing to use to feel normal* and avoid withdrawal. This transition is accompanied by changes in the brain’s reward pathways that can be visualized in the research setting. For many, heroin becomes a cheaper alternative to expensive prescription painkillers. Death from overdose can result at any point along the continuum, from medical or recreational use to addiction.

Currently, despite groundbreaking strides made in the science of addiction, there remains a chasm between evidence and practice. Like the early years of the HIV/AIDS epidemic when homophobia led to a response of blame and fear, addiction has been marginalized as a social problem. As a result, we have chosen to punish patients in many cases rather than treat them. Even for individuals able to access care, the treatment paradigm bears little resemblance to any other disease. Rather than determining eligibility based on medical necessity, individuals with addiction face stringent criteria for treatment entry, limited availability of treatment slots, long waiting lists, and a requirement to follow all rules and treatment protocols.⁵ Despite its prevalence, addiction also has been subordinated as a medical educational priority. The disparity is even apparent in our language; patients are described as “abusers,” a term that would be considered offensive if applied to another medical condition.

PARALLEL EPIDEMICS WITH A NEED FOR PARALLEL RESPONSES

While the early history of government inaction, public fear, and stigmatization of HIV/AIDS is a shameful stain on this country's conscience, 30 years later we have achieved tremendous victories, and the disease has transitioned from a veritable death sentence to a chronic condition for which most live a normal life, many with just a pill a day. The collaboration of affected communities, the public health system, physicians, and ultimately, government agencies to advance scientific understanding and disseminate an effective model of care provides lessons applicable to our current opioid epidemic.

To effectively address opioid addiction in this country, we need a comprehensive campaign for prevention, diagnosis, and treatment. Standard-of-care treatment models must be developed and disseminated based on existing evidence. Enhanced education of the medical community is necessary, and educational resources for addiction in medical training should be equivalent to that of other chronic diseases. While the intertwined issues of educational opportunity, employment, safe housing, and poverty must be acknowledged, remedying social determinants of health is not a prerequisite for implementation of effective treatment. Lastly, we could learn a lot from the HIV/AIDS campaign of "nothing for us without us" and involve patients with addiction in the design and implementation of programs meant to serve them.

There are immediate steps that can be taken to address the catastrophic death toll from unintentional overdose. Routine distribution and training in the use of naloxone, an opioid antagonist, is an effective and scalable intervention that is proven to save lives. Efforts to reformulate pain medications and decrease the availability of painkillers through physician education, prescription drug-monitoring programs, and crackdowns on "pill mills" also are important in preventing future addiction. However, we must be cognizant of those already addicted who, as the availability of pharmaceutical opioids declines in the absence of effective treatment, may turn to illicit opioids thereby introducing many other problems.

Once the HIV/AIDS epidemic was officially acknowledged, a monumental shift occurred. Dedicated resources made research and improved clinical care feasible, stigma began to recede and ultimately, people with HIV started living with rather than dying from this disease. There were enormous collateral benefits, including broad impact on scientific discovery, globalization of the public health response, and expansion of health care coverage. Such a shift can, and must, occur with opioid addiction. It is hoped that we will not have to wait 3 decades to look back and say we put an abrupt stop to these senseless deaths by marshaling government and community resources, confronting the underlying disease of opioid addiction, and eradicating stigma. The time has come to redirect our efforts from simply documenting the death toll toward effective policy change and implementation.

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